Senate Bill No. 1175

CHAPTER 214

An act to amend Sections 4603.2, 4603.4, and 4625 of the Labor Code, relating to workers' compensation.

[Approved by Governor August 26, 2016. Filed with Secretary of State August 26, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1175, Mendoza. Workers' compensation: requests for payment.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law requires the employer to provide medical, surgical, chiropractic, acupuncture, and hospital treatment, as specified, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Existing law requires a provider of those services to submit, among other documents, its request for payment with an itemization of services provided and the charge for each service. Existing law also requires the employer to reimburse the employee for his or her medical-legal expenses, as specified.

This bill would require, effective for services on or after January 1, 2017, that requests for payment with an itemization of services provided and the charge for each service be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. The bill would also require, effective for services provided on or after January 1, 2017, that all bills for medical-legal evaluation or medical-legal expense be submitted to the employer within 12 months of the date of service in the manner prescribed by the administrative director. The bill would provide that requests for payment and bills for medical-legal charges are barred unless timely submitted. The bill would require the administrative director to adopt rules to implement the 12-month limitation period, as specified.

The people of the State of California do enact as follows:

SECTION 1. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) (1) Upon selecting a physician pursuant to Section 4600, the employee or physician shall notify the employer of the name and address, including the name of the medical group, if applicable, of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination, as required by Section 6409,

and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(2) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was entitled to select the physician pursuant to Section 4600, the employee shall be entitled to continue treatment with that physician at the employer's expense in accordance with this division, notwithstanding Section 4616.2. The employer shall be required to pay from the date of the initial examination if the physician's report was submitted within five working days of the initial examination. If the physician's report was submitted more than five working days after the initial examination, the employer and the employee shall not be required to pay for any services prior to the date the physician's report was submitted.

(3) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer shall have no liability for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.

(b) (1) (A) A provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. This section does not prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

(B) Effective for services provided on or after January 1, 2017, the request for payment with an itemization of services provided and the charge for each service shall be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. The administrative director shall adopt rules to implement the 12-month limitation period. The rules shall define circumstances that constitute good cause for an exception to the 12-month period, including provisions to address the circumstances of a nonoccupational injury or illness later found to be a compensable injury or illness. The request for payment is barred unless timely submitted.

(C) Notwithstanding the requirements of this paragraph, a copy of the prescription shall not be required with a request for payment for pharmacy services, unless the provider of services has entered into a written agreement,

as provided in this paragraph, that requires a copy of a prescription for a pharmacy service.

(D) This section does not preclude an employer, insurer, pharmacy benefits manager, or third-party claims administrator from requesting a copy of the prescription during a review of any records of prescription drugs that were dispensed by a pharmacy.

(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. A properly documented list of services provided and not paid at the rates then in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:

(A) Pays the provider at the rates in effect within the 45-day period.

(B) Advises, in an explanation of review pursuant to Section 4603.3, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(3) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made within 60 days after receipt of each separate itemization, together with any required reports and any written authorization for services that may have been received by the physician.

(4) Duplicate submissions of medical services itemizations, for which an explanation of review was previously provided, shall require no further or additional notification or objection by the employer to the medical

provider and shall not subject the employer to any additional penalties or interest pursuant to this section for failing to respond to the duplicate submission. This paragraph shall apply only to duplicate submissions and does not apply to any other penalties or interest that may be applicable to the original submission.

(c) Interest or an increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of an itemization submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that itemization by the physician or medical provider. When an individual or entity conducting an itemization review determines that additional information or documentation is necessary to review the itemization, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing an itemization of service submitted by a physician or medical provider shall not alter the procedure codes listed or recommend reduction of the amount of the payment unless the documentation submitted by the physician or medical provider with the itemization of service has been reviewed by that individual or entity. If the reviewer does not recommend payment for services as itemized by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or changed other parts of the itemization and the specific deficiency in the itemization or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(e) (1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.

(B) The item and amount in dispute.

(C) The additional payment requested and the reason therefor.

(D) The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

(2) If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(f) Except as provided in paragraph (4) of subdivision (e), the appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

SEC. 2. Section 4603.4 of the Labor Code is amended to read:

4603.4. (a) The administrative director shall adopt rules and regulations to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(4) Require the timely submission of paper or electronic bills in conformity with subparagraph (B) of paragraph (1) of subdivision (b) of Section 4603.2.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

(c) Require all employers to accept electronic claims for payment of medical services.

(d) Payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made with an explanation of review by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made with an explanation of review of any uncontested amounts within 15 working days after electronic receipt of the billing, and payment of the balance shall be made in accordance with Section 4603.2.

SEC. 3. Section 4625 of the Labor Code is amended to read:

4625. (a) Effective for services provided on or after January 1, 2017, all bills for medical-legal evaluation or medical-legal expense shall be submitted to the employer within 12 months of the date of service in the manner prescribed by the administrative director. The administrative director

shall adopt rules to define circumstances that constitute good cause for an exception to the 12-month period. Bills for medical-legal charges are barred unless timely submitted.

(b) Notwithstanding subdivision (d) of Section 4628, all charges for medical-legal expenses for which the employer is liable that are not in excess of those set forth in the official medical-legal fee schedule adopted pursuant to Section 5307.6 shall be paid promptly pursuant to Section 4622.

(c) If the employer contests the reasonableness of the charges it has paid, the employer may file a petition with the appeals board to obtain reimbursement of the charges from the physician that are considered to be unreasonable.

O